Understanding Montana Workers' Compensation (WC) Facility Fee Schedule UNIT TWO: USING THE UB-04

New updates of information, similar to FAQ, will be added to this educational module on a regular basis, so please check the date at the bottom of this page regularly to keep up with added fee schedule information.

A Power Point educational module initially created by the Montana Department of Labor (DLI) in March, 2009. Actual regulations in the Montana Code Annotated and Administrative Rules of Montana, of course, take precedence in case of any misstatements in this educational module.

July 16, 2009

Unit Two:
Using The UB-04: Billing Forms for the Montana MS-DRG (inpatient) and APC (outpatient) Facility Fee Schedule

For use with the Montana Facility Fee Schedule for Workers' Compensation (WC) Reimbursement

What You Need To Do First

This educational module is designed based on the assumption that you have already learned the materials in **Unit One: Essential Information about the Montana Facility Fee Schedules for Workers' Compensation Insurance.**

Unit One is located on this same state web page, so you should be able to find it easily and master its contents before beginning this second unit.

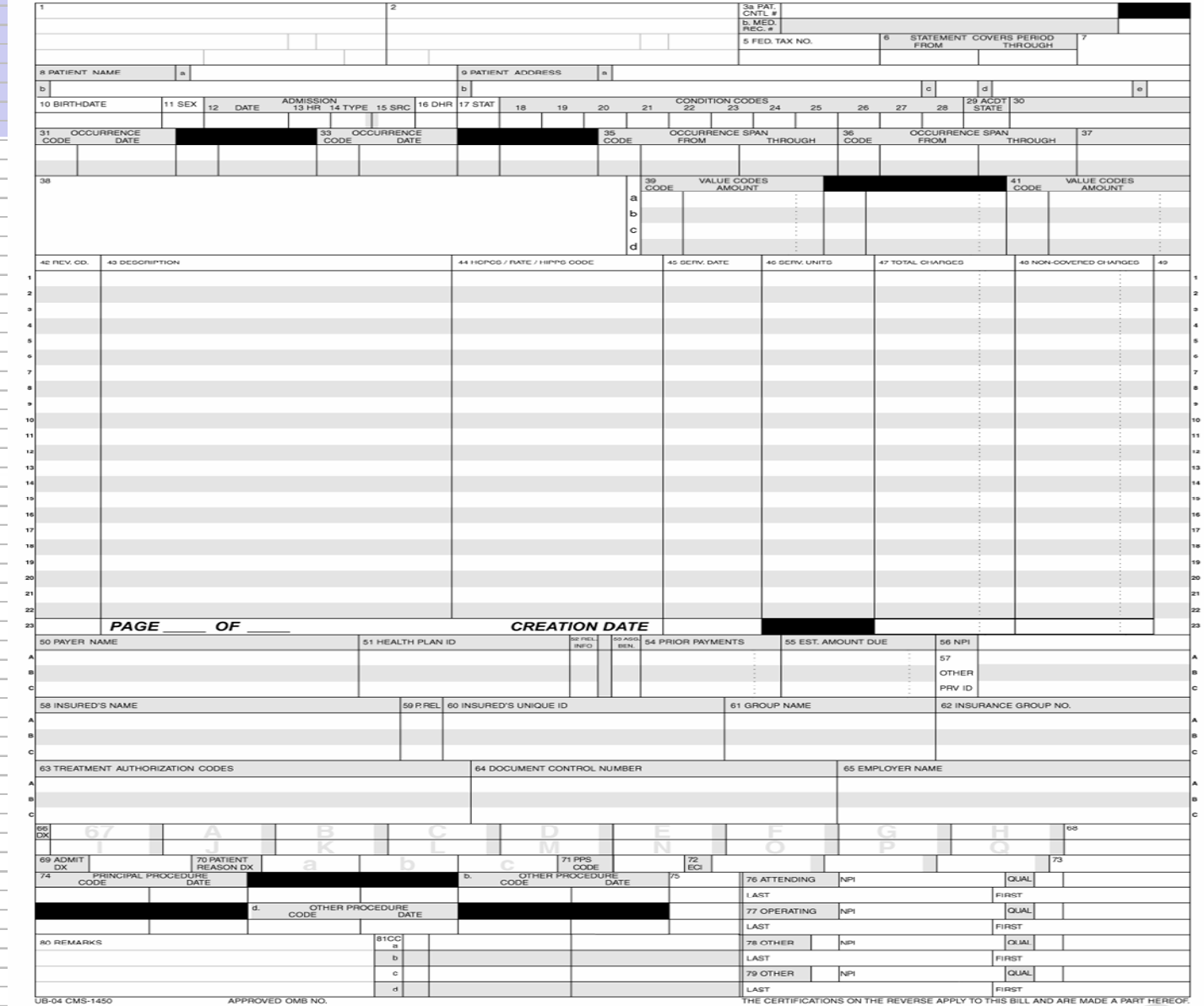
Educational Module Organization

- **Section One: Locating required Information on the UB-04 Form**
- **Section Two: Examples of Processing Inpatient (MS-DRG) Bills**
- **Section Three: Examples of Processing Outpatient (APC) Bills**
- **Section Four: Other Ways of Paying**
- **Section Five: Equivalences in the 1500 Form**
- **Section Six: Other Resources**

Get Ready to Process UB-04s

- **Unit One** introduced you to the Grouper/Pricer concept for determining MS-DRGs and APCs, and gave a few examples of the billing process for the Montana WC reimbursement system.
- This **Unit Two** provides multiple examples of how to process the WC bill for payment. If, after working through all these examples, you still cannot complete a particular bill, please send us an email at wwilkison@mt.gov and we will attempt to help you. Meanwhile, for correlation purposes over the next few slides discussing portions of the UB-04 form, the very next slide is an image of the UB-04 form as a whole.
- **Tools you need to most effectively learn from this module**: 1) a hard copy of the one-page "(g) The MT Status Indicator (SI) codes" listing from our Montana Facility Fee Schedule; 2) a computer screen open to the appropriate MS-DRG or APC subsections of our Facility Fee Schedule; and 3) a computer screen open to the www.hospitalbenchmarks.com Grouper, or some way to toggle easily between 2) and 3) on one computer screen.

This is an image of the UB-04 Form



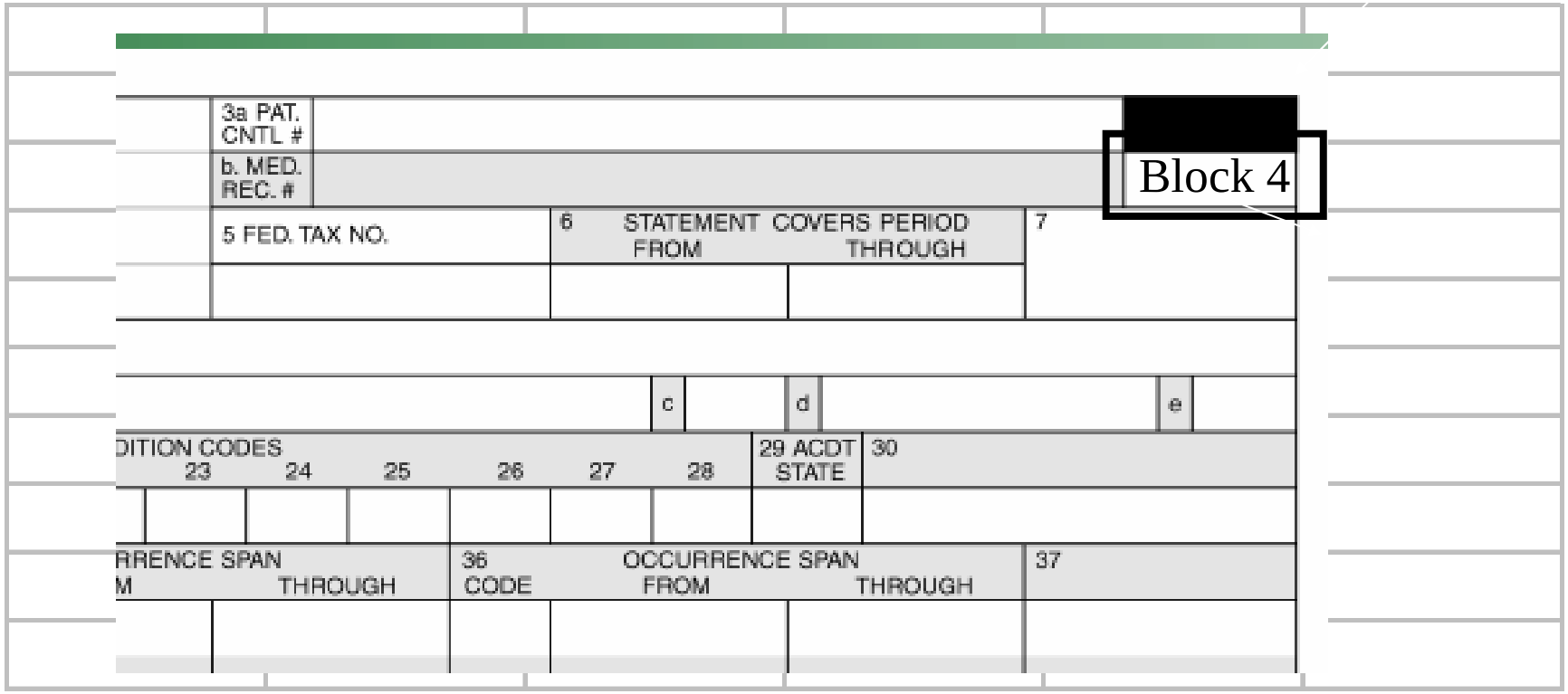
What does the UB-04 form tell me?

Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into Block 4 on the upper right corner of the UB-04 form is either

- **0111 (inpatient services, for which you use a MS-DRG Grouper) or**
- **0131 (outpatient services, for which you use the APC codes and process, as described later in this learning module)**
- **There are quite a few other codes that can be entered in Block 4, but most may be payable at one of the 75 percent reimbursement rates described in Section Four of this learning module**

Right Upper Corner of UB-04, Block 4

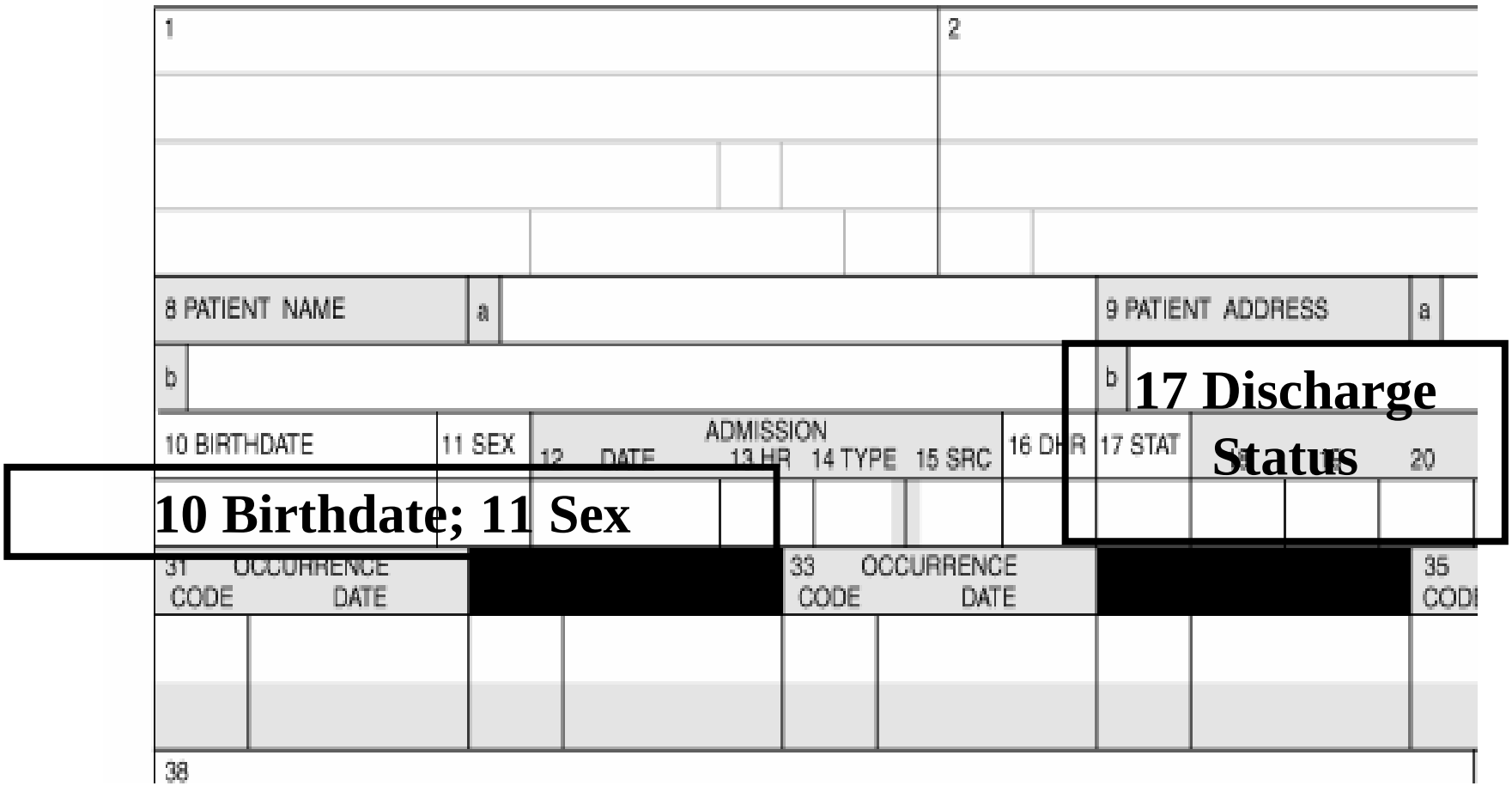


Does Block 4 include 111, 131, or another code?

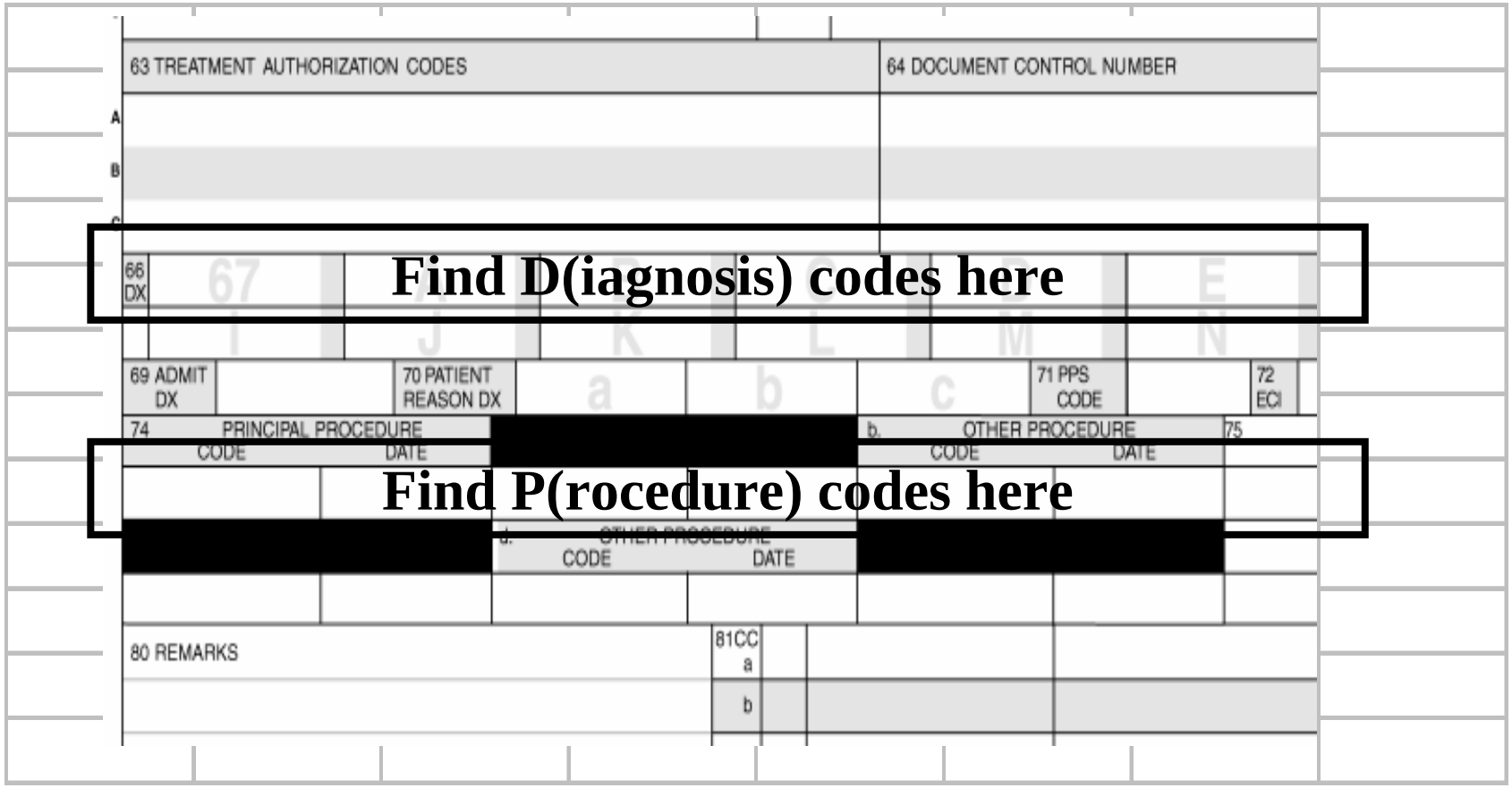
Where do we find the required claimant information?

- **Patient information (age, sex, discharge status) is in the upper left corner**
- **Medical information (Diagnosis & Procedures) is in the lower left corner**

Required Patient Status Information is in the upper left portion of the UB-04



D & P Codes are Located in the Lower Left Corner of the UB-04



From the UB-04 to the Grouper

- Now that we know where to find the required UB-04 data to enter into a Grouper, let's go over the use of the MS-DRG Grouper
- First, open up the free Grouper at www.hospitalbenchmarks.com so that we can generate a corresponding Medicare Severity-Diagnosis Related Group (MS-DRG) classification code

Summary from Unit One On the Use of the Grouper

Using an MS-DRG Grouper with a UB-04 (see the sample UB-04 and Grouper form on the next three slides):

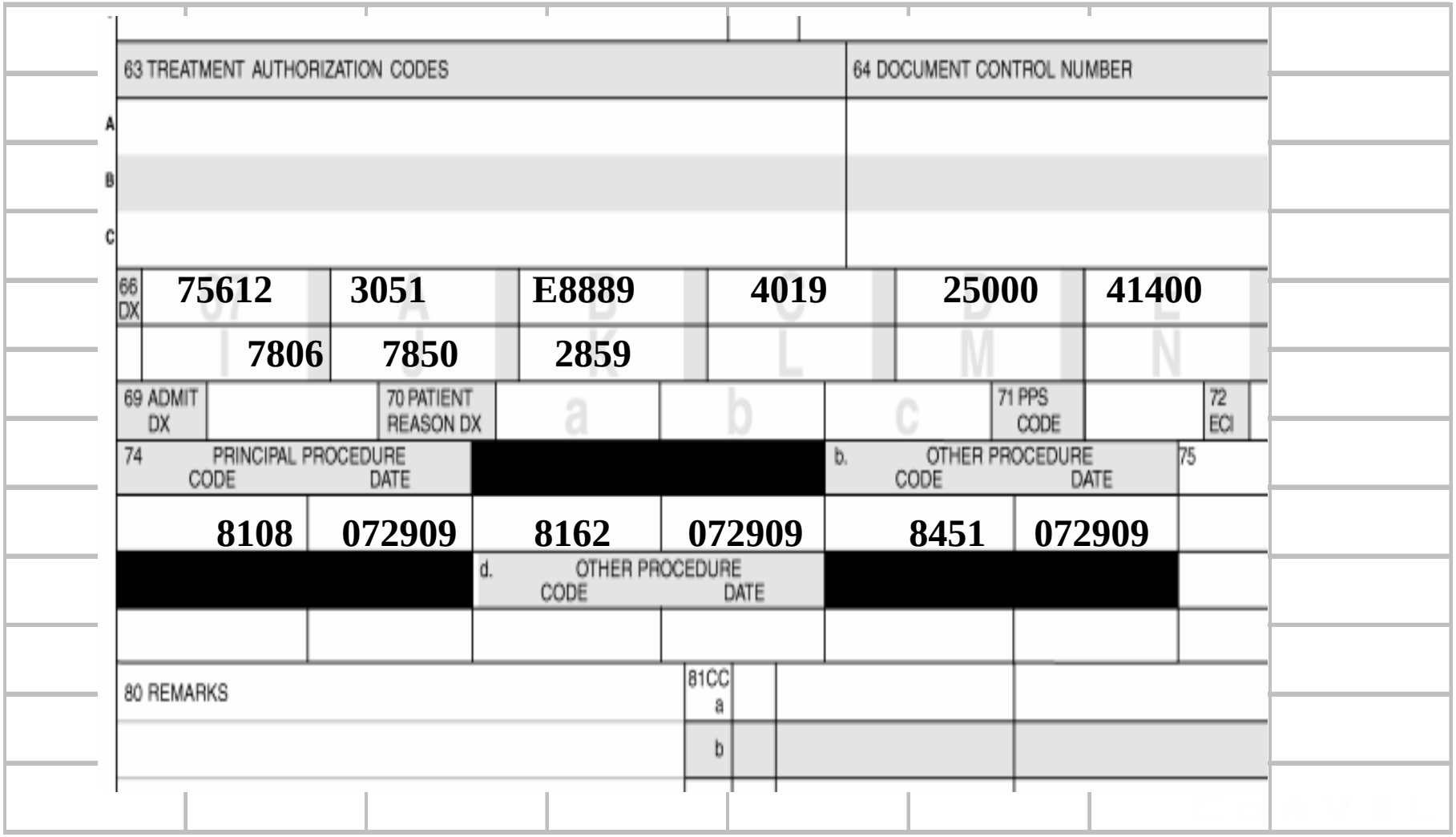
1) **Enter Patient information from the UB-04 onto the first page of the Grouper**

2) **Identify the Diagnosis (D) and Procedure (P) Codes on the UB-04, & proceed only if Block 4 includes code 0111 (which equates to inpatient services)**

3) **Insert the D & P Codes in the order, left to right, as they appear on the UB-04, into the correct cells on the Grouper. As you enter the D & P codes, remember to not include the decimal. Once you have all codes inputted, press the "Group & Compare" button. Remember also that the number of cells (or blocks) available on the Grouper for input represent the maximum number of D&P codes that create the MS-DRG code.**

4) **Confirm the reimbursement amount cited by the Grouper-generated MS-DRG code with the Montana Facility Fee Schedule section listing that MS-DRG code. Note also that Montana uses a rounding whole dollar reimbursement calculation for the MS-DRG reimbursement.**

Example #1: Enter the medical data (D & P) from the lower left-hand corner of the UB-04 into the Grouper



63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER
A	
B	
C	

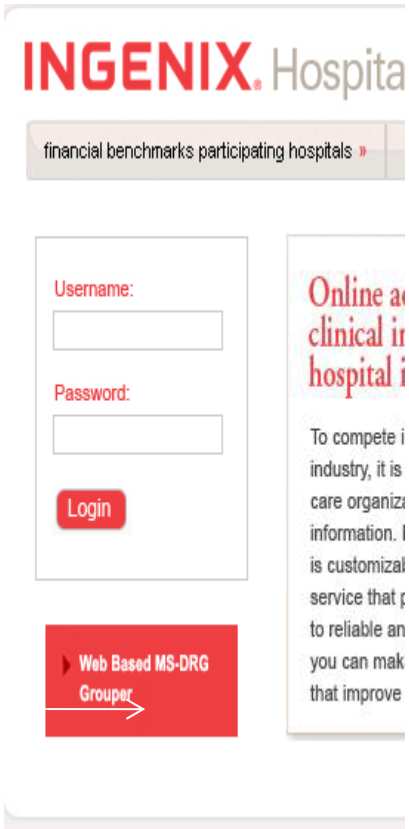
66 DX						
	75612	3051	E8889	4019	25000	41400
	7806	7850	2859			

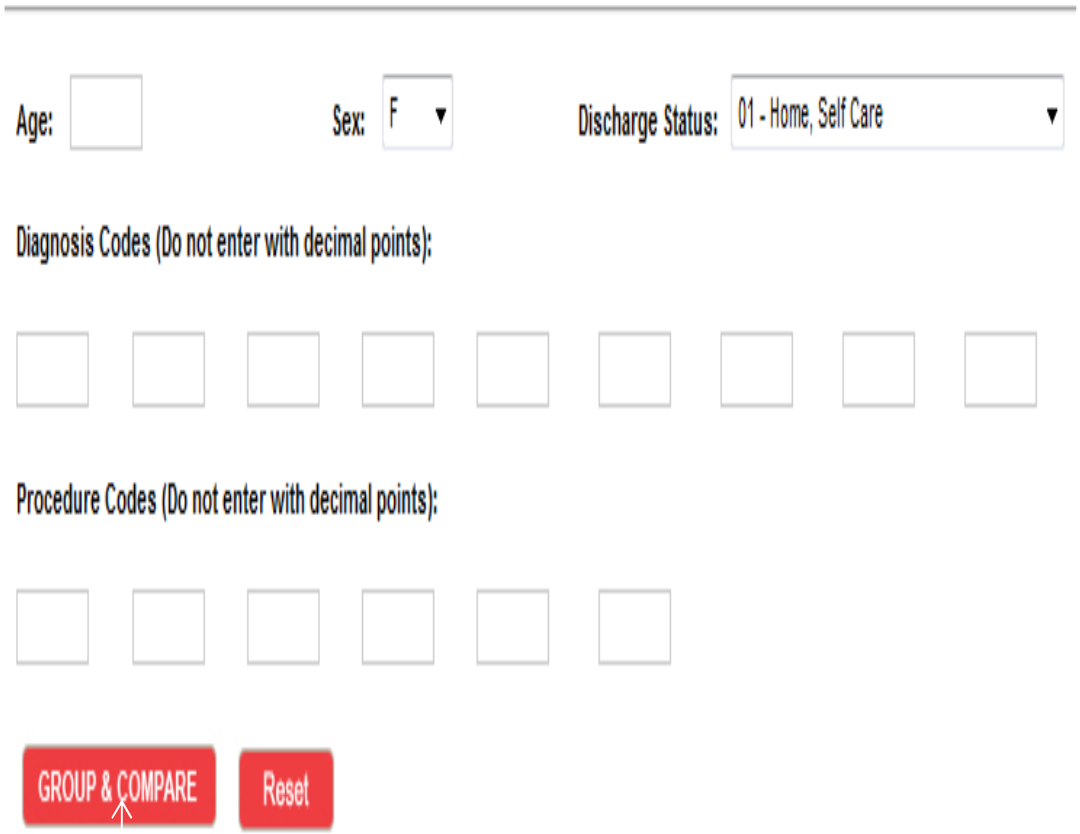
69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI

74 PRINCIPAL PROCEDURE CODE	DATE			b. OTHER PROCEDURE CODE	DATE	75
8108	072909	8162	072909	8451	072909	
		d. OTHER PROCEDURE CODE	DATE			

80 REMARKS	81CC a			
	b			

Example #1 in the Grouper (page 1 of 2)





Example #1 in the Grouper (page 2 of 2)

Diagnosis Codes (Do not enter with decimal points):

75612	3051	e8889	4019	25000	41400	7806	7850	2859

Procedure Codes (Do not enter with decimal points):

8108	8162	8451			

GROUP & COMPARE Reset

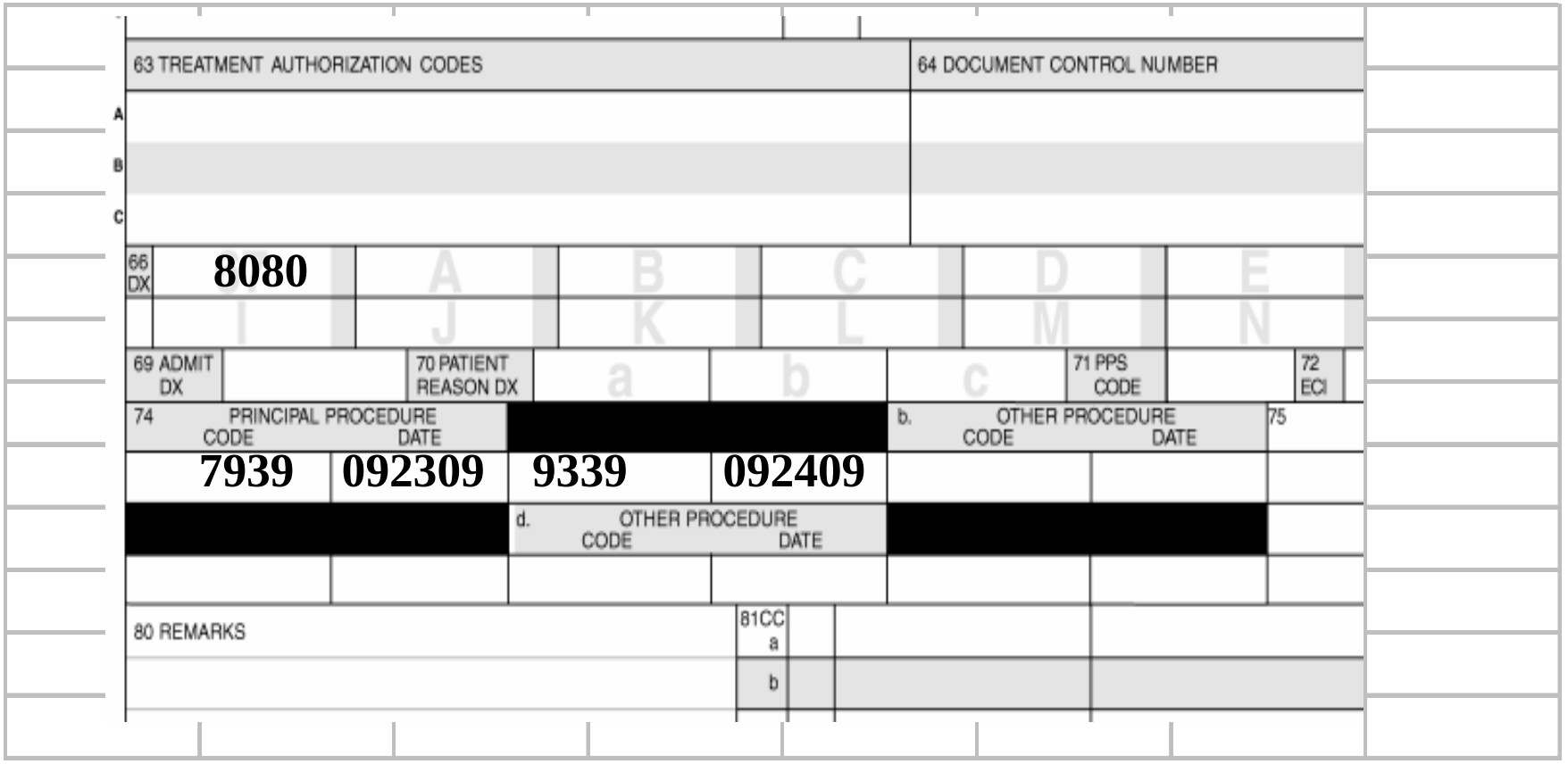
Grouping Results:

CMS v24 DRG Assignment:	498 (SPINAL FUSION EXCEPT CERVICAL W/O CC) **[Pre MS-DRG year**
CMS v25 (MS) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC) **Last year MS-DRG**
CMS v26 (MS FY2009) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC) **Current year MS-DRG]**
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)
CMS v24 DRG Weight:	2.9896
CMS v25 (MS) DRG Weight:	3.4870
CMS v26 (MS FY2009) DRG Weight:	3.5607
CC Diagnosis:	None
MCC Diagnosis:	None
*	Updated to CMS final rule.

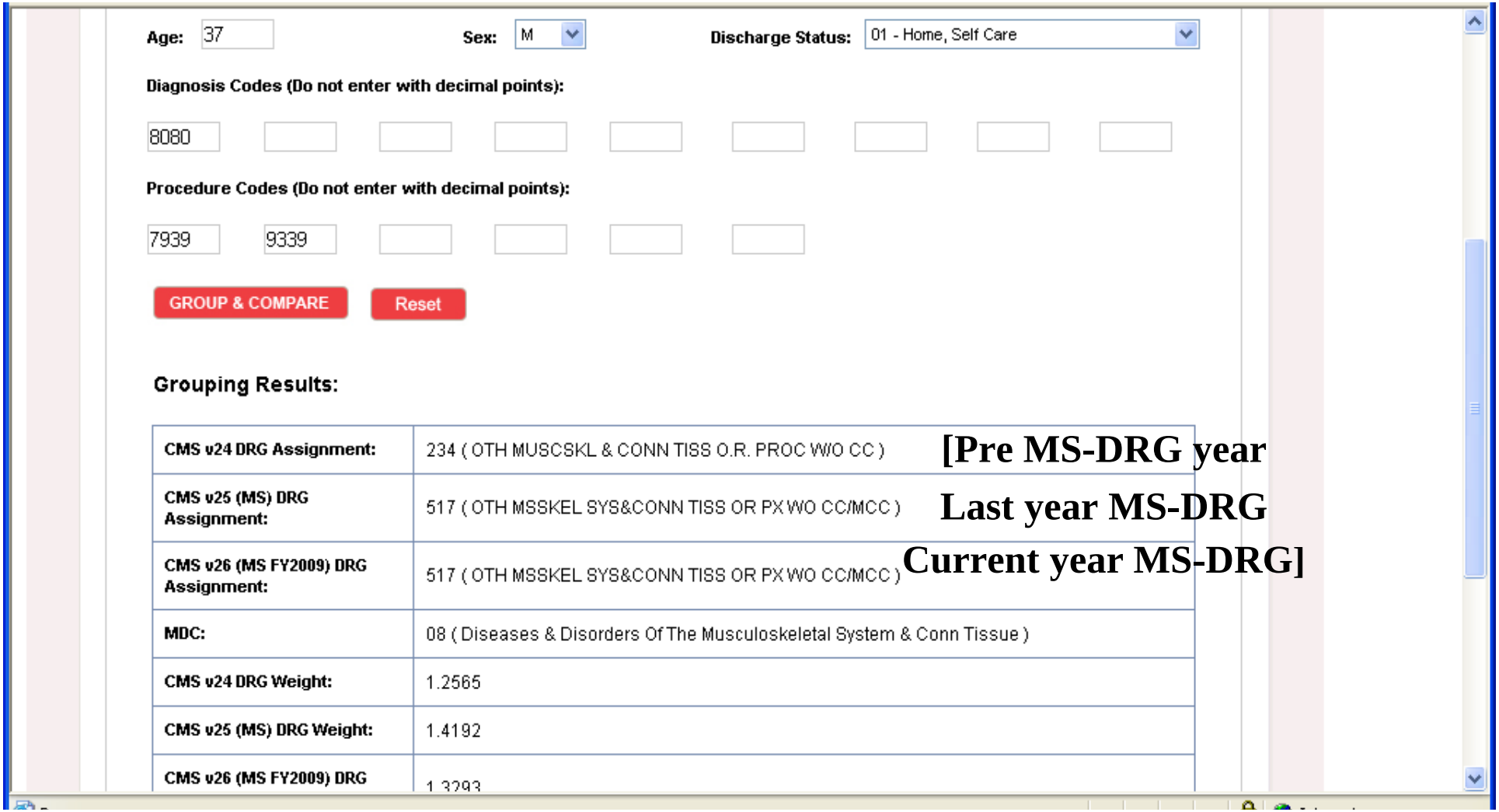
Example # 1: Working through the process

- **For this claim example #1, MS-DRG 460 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount. (The Grouper will also provide the MS-DRG weight of 3.5607 for the current version (26) of the MS-DRG calculation, but usually you will not need to deal with these kinds of details) If you are interested in the mechanics of the calculation, the MS-DRG weight (3.5607) is multiplied by the Montana Base rate ($7,735) = $27,542.**
- **MS-DRG 460 is reimbursed by the Montana Facility Fee Schedule at $27,542. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls.**
- **On row 23, column 47 of the UB-04 is the cell "Total Charges." Each time you process a claim, make sure you compare the "Total Charges" amount to the MS-DRG reimbursement. If "Total Charges" equals three times or more the MS-DRG reimbursement amount, you may have to make an outlier adjustment, as we will describe later in this learning module.**

MS-DRG claim example # 2: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.



For example # 2, the MS-DRG is 517, which according to "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at $10,282



Age: 37 Sex: M Discharge Status: 01 - Home, Self Care

Diagnosis Codes (Do not enter with decimal points):

8080

Procedure Codes (Do not enter with decimal points):

7939 9339

GROUP & COMPARE Reset

Grouping Results:

CMS v24 DRG Assignment:	234 (OTH MUSCSKL & CONN TISS O.R. PROC W/O CC)
CMS v25 (MS) DRG Assignment:	517 (OTH MSSKEL SYS&CONN TISS OR PX W/O CC/MCC)
CMS v26 (MS FY2009) DRG Assignment:	517 (OTH MSSKEL SYS&CONN TISS OR PX W/O CC/MCC)
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)
CMS v24 DRG Weight:	1.2565
CMS v25 (MS) DRG Weight:	1.4192
CMS v26 (MS FY2009) DRG	1.3293

[Pre MS-DRG year

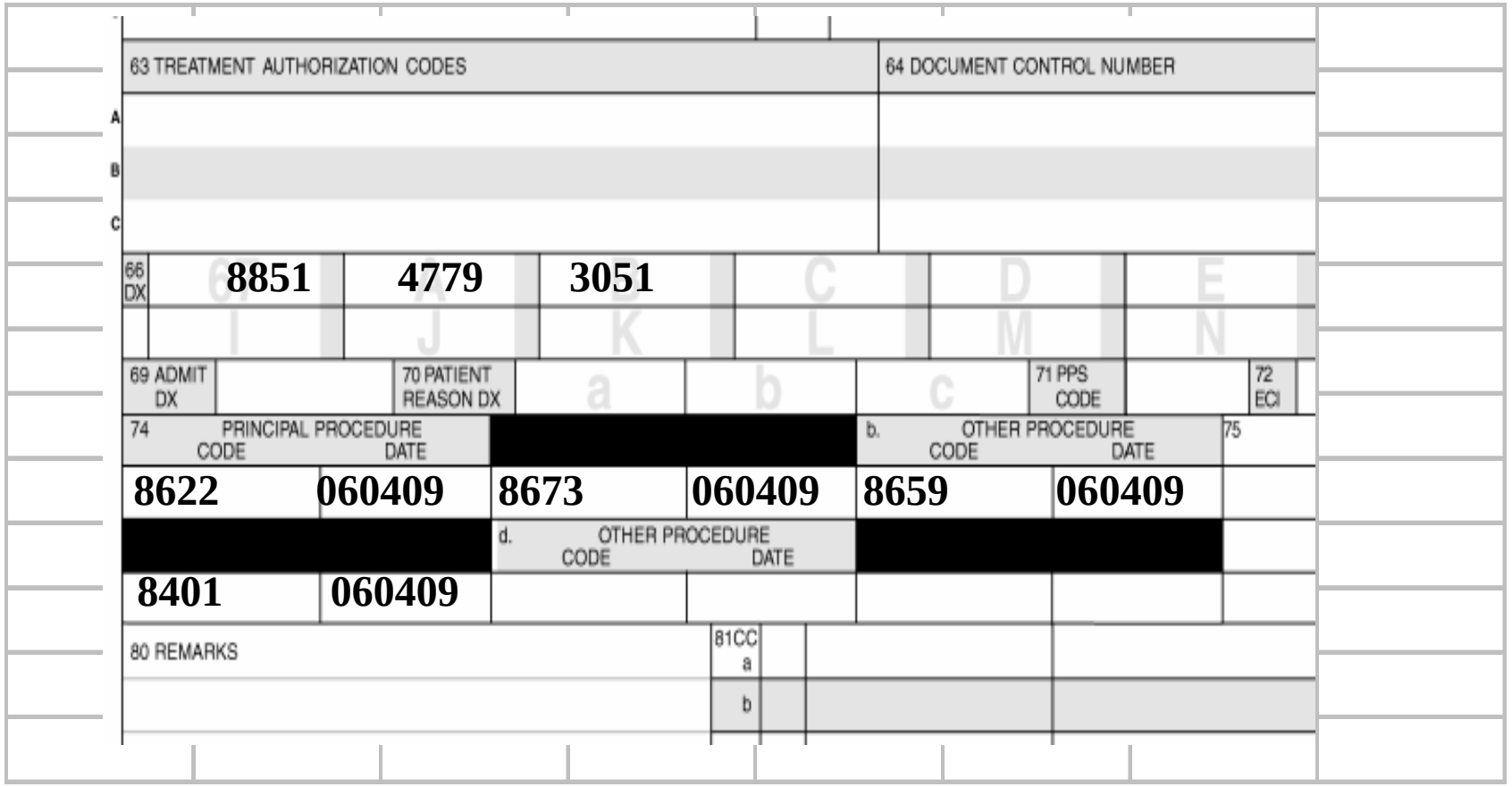
Last year MS-DRG

Current year MS-DRG]

Example # 2: Working through the process

- **For this claim example # 2, MS-DRG 517 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.**
- **MS-DRG 517 is reimbursed by the Montana Facility Fee Schedule at $10,282. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls**
- **On row 23, column 47 of the UB-04 is the cell "Total Charges." Each time you process a claim, make sure you compare the "Total Charges" amount to the MS-DRG reimbursement. If "Total Charges" equals three times or more the MS-DRG reimbursement amount, you may have to make an outlier adjustment, as we will describe later in this learning module.**

MS-DRG claim example # 3: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.



63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER
A	
B	
C	

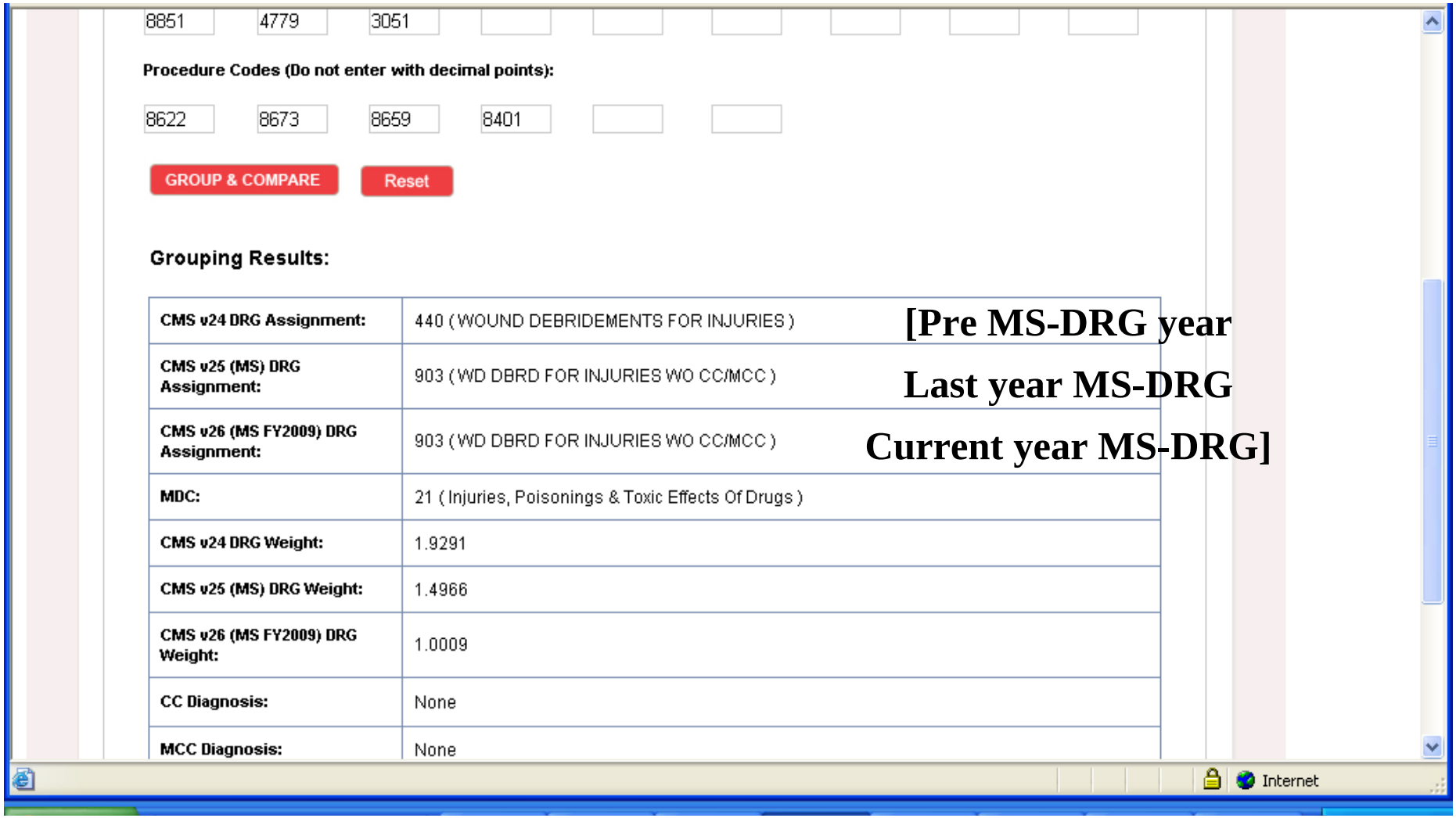
66 DX	8851	4779	3051	C	D	E
	I	J	K	L	M	N

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI

74 PRINCIPAL PROCEDURE CODE	DATE			b. OTHER PROCEDURE CODE	DATE	75
8622	060409	8673	060409	8659	060409	
		d. OTHER PROCEDURE CODE	DATE			
8401	060409					

80 REMARKS	81CC a		
	b		

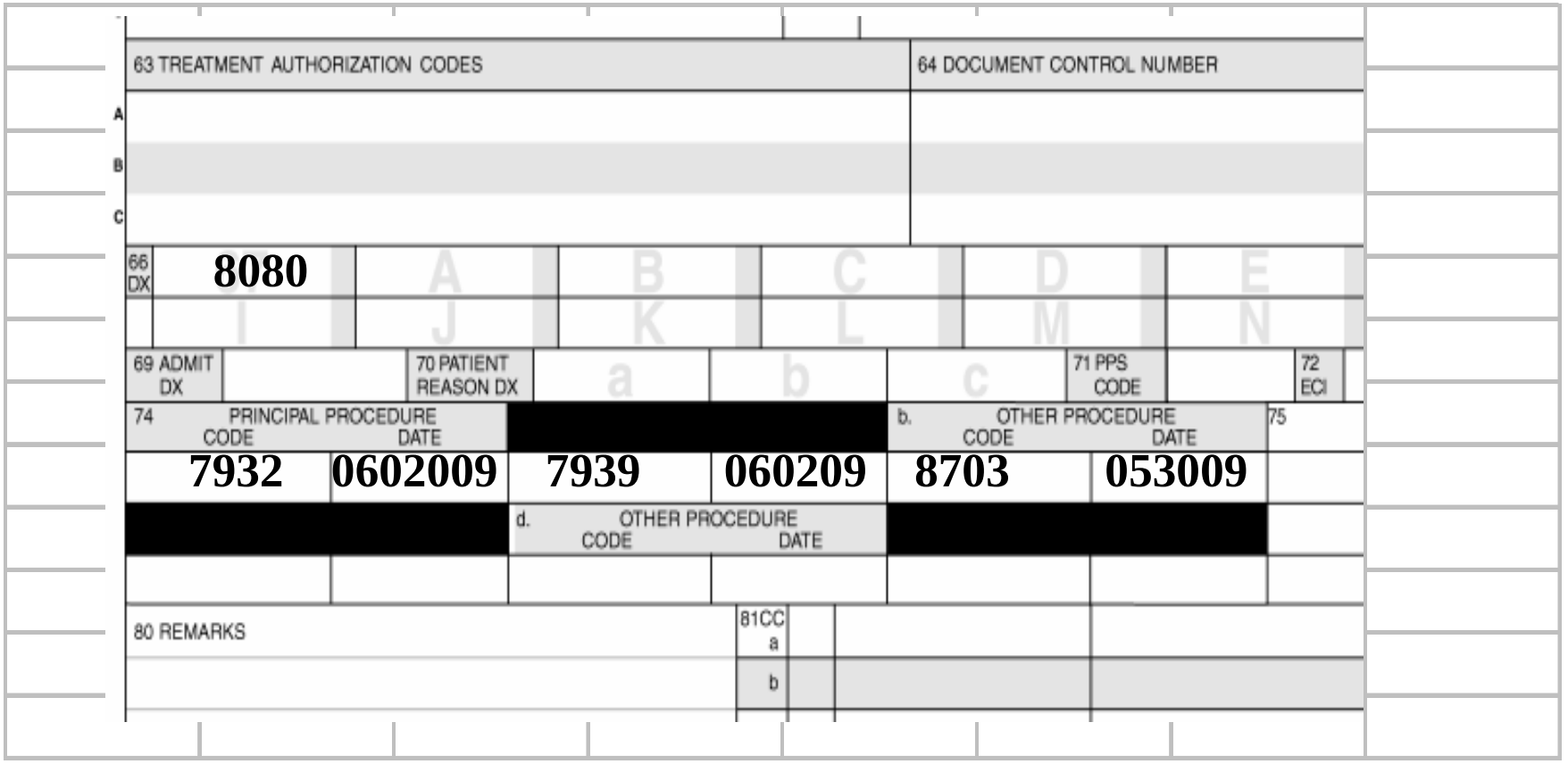
Example # 3: in this example, the MS-DRG is 903, which according to "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at $7,742



Example # 3: Working through the process

- **For this claim example # 3, MS-DRG 903 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.**
- **MS-DRG 903 is reimbursed by the Montana Facility Fee Schedule at $7,742. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls**
- **On row 23, column 47 of the UB-04 is the cell "Total Charges." Each time you process a claim, make sure you compare the "Total Charges" amount to the MS-DRG reimbursement. If "Total Charges" equals three times or more the MS-DRG reimbursement amount, you may have to make an outlier adjustment, as we will describe later in this learning module.**

MS-DRG claim example # 4: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.



63 TREATMENT AUTHORIZATION CODES						64 DOCUMENT CONTROL NUMBER					
A											
B											
C											

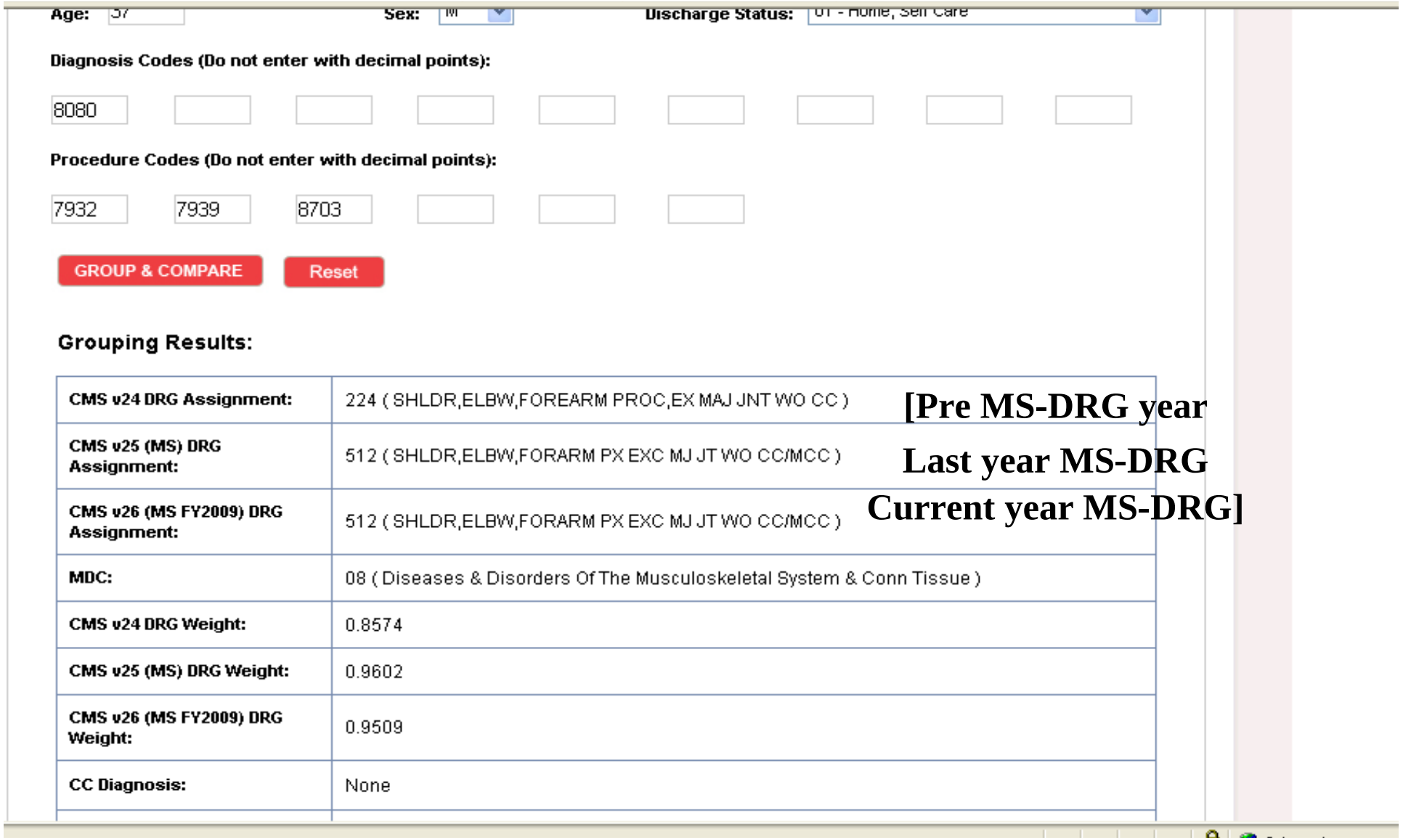
66 DX	8080	A	B	C	D	E
		I	J	K	L	M	N

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	

74 PRINCIPAL PROCEDURE CODE	DATE			b. OTHER PROCEDURE CODE	DATE	75
7932	0602009	7939	060209	8703	053009	
		d. OTHER PROCEDURE CODE	DATE			

80 REMARKS	81CC a			
	b			

Example # 4: in this example, the MS-DRG is 512, which according to (a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at $7,355



Age: 57 Sex: M Discharge Status: 01 - Home, Self Care

Diagnosis Codes (Do not enter with decimal points):

8080

Procedure Codes (Do not enter with decimal points):

7932 7939 8703

GROUP & COMPARE Reset

Grouping Results:

CMS v24 DRG Assignment:	224 (SHLDR,ELBW,FOREARM PROC,EX MAJ JNT WO CC)
CMS v25 (MS) DRG Assignment:	512 (SHLDR,ELBW,FORARM PX EXC MJ JT WO CC/MCC)
CMS v26 (MS FY2009) DRG Assignment:	512 (SHLDR,ELBW,FORARM PX EXC MJ JT WO CC/MCC)
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)
CMS v24 DRG Weight:	0.8574
CMS v25 (MS) DRG Weight:	0.9602
CMS v26 (MS FY2009) DRG Weight:	0.9509
CC Diagnosis:	None

[Pre MS-DRG year

Last year MS-DRG

Current year MS-DRG]

Example # 4: Working through the process

- **For this claim example # 4, MS-DRG 512 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.**
- **MS-DRG 512 is reimbursed by the Montana Facility Fee Schedule at $7,355. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli. mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls**
- **On row 23, column 47 of the UB-04 is the cell "Total Charges." Each time you process a claim, make sure you compare the "Total Charges" amount to the MS-DRG reimbursement. If "Total Charges" equals three times or more the MS-DRG reimbursement amount, you may have to make an outlier adjustment, as we will describe later in this learning module.**

MS-DRG claim example # 5: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.

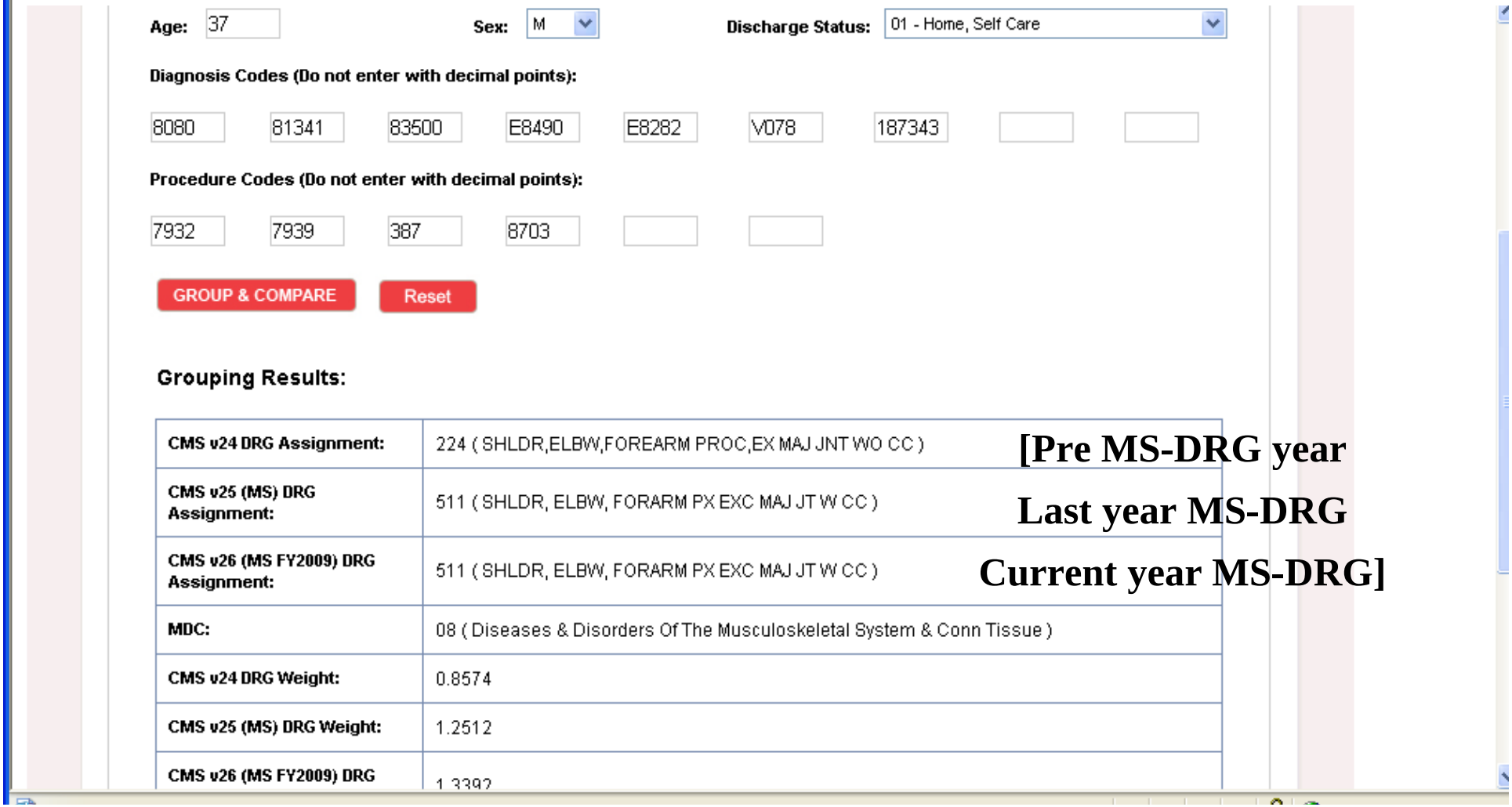
63 TREATMENT AUTHORIZATION CODES						64 DOCUMENT CONTROL NUMBER	
A							
B							
C							
66 DX	8080	81341	83500	E8282	V078	187343	
	I	J	K	L	M	N	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	

74 PRINCIPAL PROCEDURE CODE	DATE			b. OTHER PROCEDURE CODE	DATE	75	
7932	060209	7939	060209	387	060209		
		d. OTHER PROCEDURE CODE	DATE				
8703	053009						

80 REMARKS	81CC a			
	b			

For example # 5, the MS-DRG is 511, which according to "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule," should be reimbursed at $10,359.



Age: 37 Sex: M Discharge Status: 01 - Home, Self Care

Diagnosis Codes (Do not enter with decimal points):

8080 | 81341 | 83500 | E8490 | E8282 | V078 | 187343 | | |

Procedure Codes (Do not enter with decimal points):

7932 | 7939 | 387 | 8703 | | |

GROUP & COMPARE Reset

Grouping Results:

CMS v24 DRG Assignment:	224 (SHLDR,ELBW,FOREARM PROC,EX MAJ JNT WO CC)
CMS v25 (MS) DRG Assignment:	511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC)
CMS v26 (MS FY2009) DRG Assignment:	511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC)
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)
CMS v24 DRG Weight:	0.8574
CMS v25 (MS) DRG Weight:	1.2512
CMS v26 (MS FY2009) DRG	1.3392

[Pre MS-DRG year

Last year MS-DRG

Current year MS-DRG]

Example # 5: Working through the process

- **For this claim example # 5, MS-DRG 511 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.**
- **MS-DRG 511 is reimbursed by the Montana Facility Fee Schedule at $10,359. You can find both the MS-DRG code and its reimbursement amount in "(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule" portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor's web page at http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls**
- **There is a new element in this bill, namely that the bill charges on the UB-04 total $41,092 at row 23, column 47, which is more than three times the MS-DRG normal reimbursement amount of $10,359, so this claim example is likely to be an outlier.**

Example # 5 (continued)

Inpatient Outliers

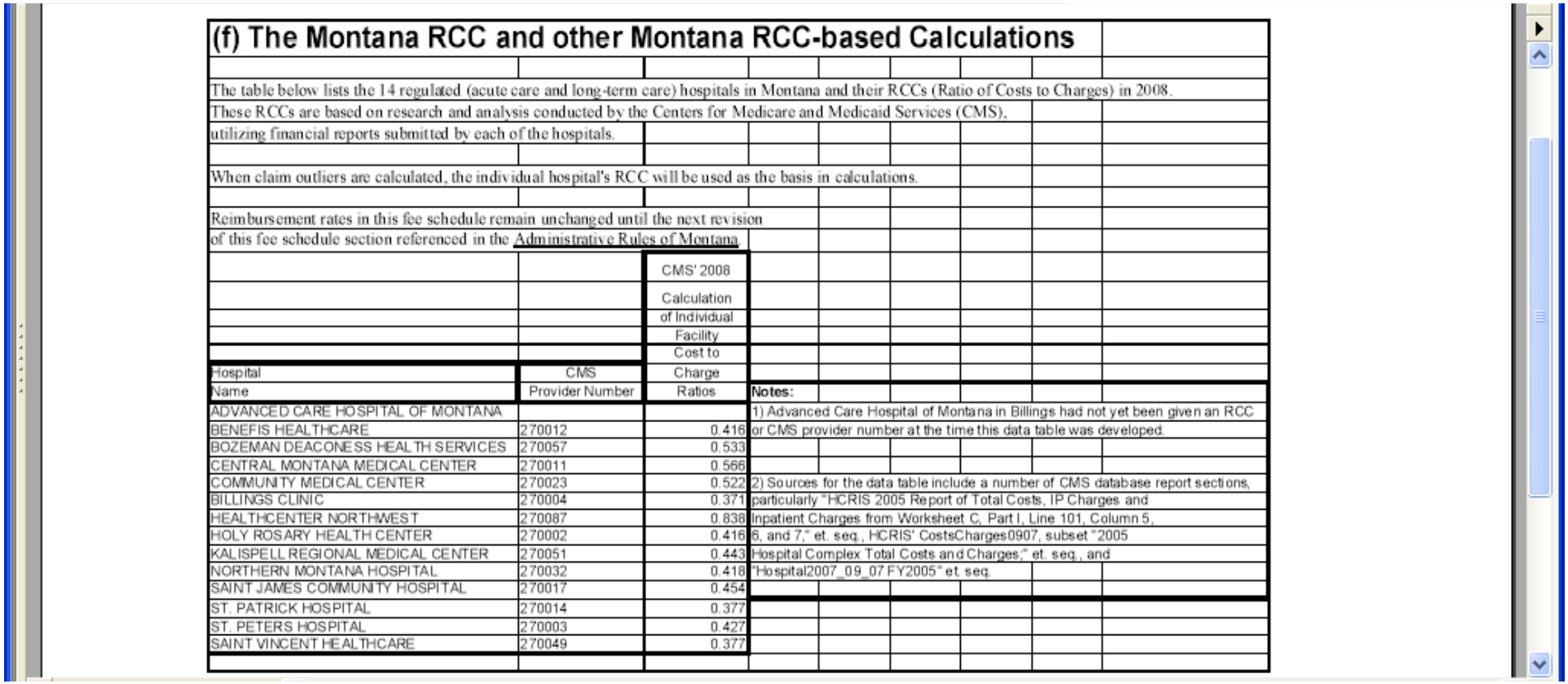
- The MS-DRG system is intended to meet the majority of all inpatient reimbursement needs
- Occasionally very high medical costs associated with a particular case, known as outlier costs, may require additional reimbursement to the facility

Example # 5 (continued)

Calculating Outlier Payments

- **Charges must meet the outlier threshold formula established by the Administrative Rules of Montana (ARM) for inpatient outlier costs**
- **The threshold formula is the MS-DRG payment multiplied by 3**
- **[Charges - (MS-DRG payment x 3)] x (RCC plus 15%)**
- **There is a different RCC (Ratio of Cost-to-Charge) for each Montana Hospital (for the RCCs, see "(f) The Montana RCC and other Montana RCC-based Calculations" section of the Montana Facility Fee Schedule)**

The Ratio of Costs-to-Charges for Each Hospital are listed on "(f) The Montana RCC and other Montana RCC-based Calculations" section of the Montana Facility Fee Schedule, located on our webpage



(f) The Montana RCC and other Montana RCC-based Calculations

The table below lists the 14 regulated (acute care and long-term care) hospitals in Montana and their RCCs (Ratio of Costs to Charges) in 2008.
These RCCs are based on research and analysis conducted by the Centers for Medicare and Medicaid Services (CMS), utilizing financial reports submitted by each of the hospitals.

When claim outliers are calculated, the individual hospital's RCC will be used as the basis in calculations.

Reimbursement rates in this fee schedule remain unchanged until the next revision of this fee schedule section referenced in the Administrative Rules of Montana.

Hospital Name	CMS Provider Number	CMS' 2008 Calculation of Individual Facility Cost to Charge Ratios
ADVANCED CARE HOSPITAL OF MONTANA		
BENEFIS HEALTHCARE	270012	0.416
BOZEMAN DEACONESS HEALTH SERVICES	270057	0.533
CENTRAL MONTANA MEDICAL CENTER	270011	0.566
COMMUNITY MEDICAL CENTER	270023	0.522
BILLINGS CLINIC	270004	0.371
HEALTHCENTER NORTHWEST	270087	0.838
HOLY ROSARY HEALTH CENTER	270002	0.416
KALISPELL REGIONAL MEDICAL CENTER	270051	0.443
NORTHERN MONTANA HOSPITAL	270032	0.418
SAINT JAMES COMMUNITY HOSPITAL	270017	0.454
ST. PATRICK HOSPITAL	270014	0.377
ST. PETERS HOSPITAL	270003	0.427
SAINT VINCENT HEALTHCARE	270049	0.377

Notes:

1) Advanced Care Hospital of Montana in Billings had not yet been given an RCC or CMS provider number at the time this data table was developed.

2) Sources for the data table include a number of CMS database report sections, particularly "HCRIS 2005 Report of Total Costs, IP Charges and Inpatient Charges from Worksheet C, Part I, Line 101, Column 5, 6, and 7," et. seq., HCRIS' CostsCharges0907, subset "2005 Hospital Complex Total Costs and Charges," et. seq., and "Hospital2007_09_07 FY2005" et. seq.

Example # 5 (continued)

Calculating the outlier for Billings Clinic:

- **Medical charges total $41,092,**
- **And the MS-DRG Payment is $10,359,**
- **And the outlier threshold is $31,077,**
- **And the RCC (Ratio of Cost-to-Charge) is 0.371,**
- **Then the outlier payment = ($41,092-($10,359x3)) x (0.371 + .15) = $5,217 to be added to the regular reimbursement**
- **Therefore total payment is $10,359 + $5,217 = $15,577**

Other Considerations

Pay the Bill based on the Fee Schedule

MS-DRG rates are based on a "case mix" formula, so insurers should pay the actual fee schedule reimbursement amount, instead of a higher or lower reimbursement amount the medical provider might bill

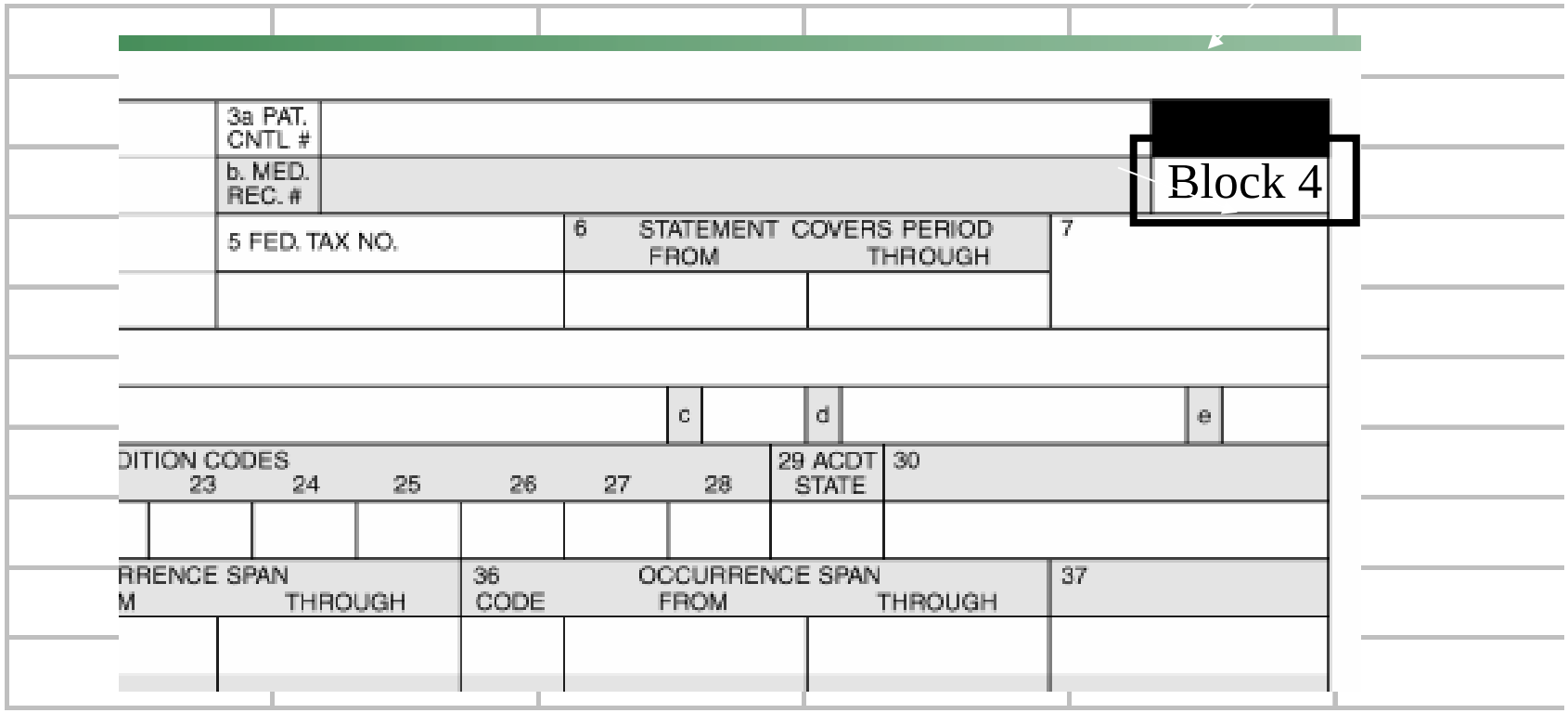
Section Three: Utilizing the UB-04 to Reimburse Outpatient (APC) Bills

Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into Block 4 on the upper right corner of the UB-04 form is either

- **0111 (inpatient services, for which you use a MS-DRG Grouper as you have just learned above) or**
- **0131 (outpatient services, for which you use the APC codes and process, as we will now describe in this section of the learning module). Remember also that the APC reimbursement system is also used by Ambulatory Surgery Centers (ASCs) for billing and reimbursement purposes, so ASC bill information also follows this APC billing process.**
- **There are quite a few other facility-related codes that can be entered in Block 4, but most may be payable at one of the 75 percent reimbursement rates described below in Section Four of this learning module**

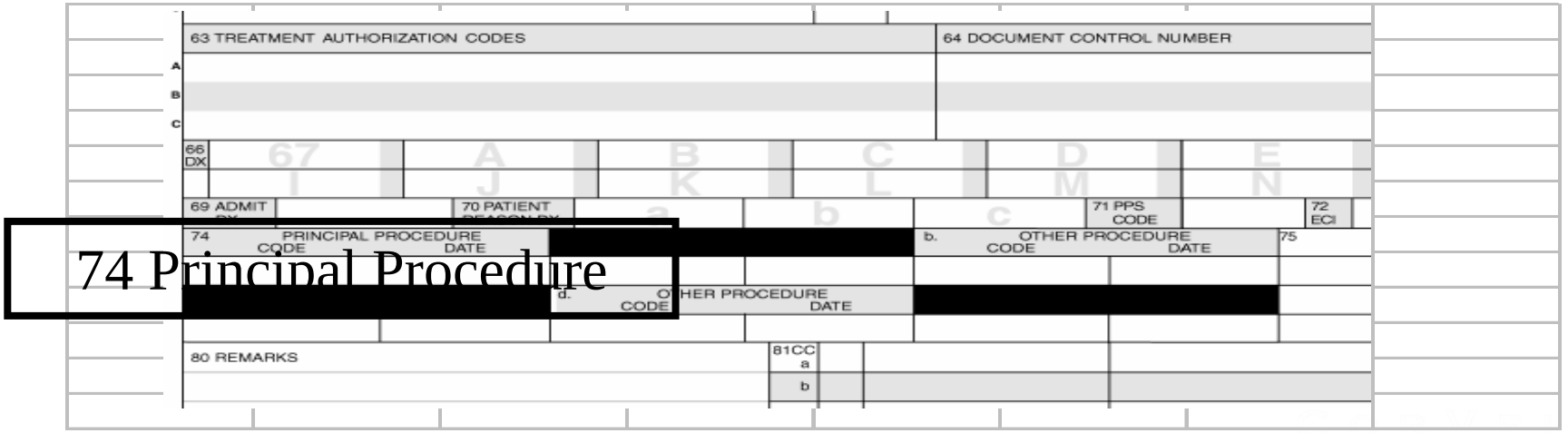
Upper Right Corner of UB-04, Block 4



Does Block 4 include 111, 131, or another code?

The APC Process is more manual: Finding the Matching CPT/APC Codes

- **If the UB-04 has code 131 in Block 4, you are all set to process the Outpatient billing**
- **<u>Step 1:</u> Look up the "Principal Procedure" (PP) code in cell # 74 of the D & P portion of the UB-04, and then compare that PP code to the CPT codes in the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" section of the <u>Montana Facility Fee Schedule</u>. You may find that you have to use the CPT/HCPCS code(s) from the middle of the UB-04 form (the large cell "44 HCPCS") to locate the appropriate CPT/HCPCS codes to match against the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized bye CPT/HCPCS" section.**



The APC Process is more manual: Finding the Reimbursement Value of the APC Code

- **Step 2: With the APC code identified, use "(b) The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" of the Montana Facility Fee Schedule to determine the APC reimbursement amount. Remember to select either the "Hospital APC Payment" or "ASC APC Payment" column to properly pay the facility's APC reimbursement.**
- **Step 3: Return to the non-principal Procedure codes on the UB-04 and identify their respective Status Indicator (SI) codes by looking them up in the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" section of the Montana Facility Fee Schedule**
- **Each Status Indicator code will assist you in determining whether the individual non-principal Procedure codes are to be paid separately, are discounted, or are "built into" the APC reimbursement amount already determined for the Principal Procedure code.**

The APC Process is more manual: Finding the Reimbursement Value of the Remaining CPT codes via Status Indicator codes

The "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" fee schedule listing includes an entire column (second from left) with Status Indicator (SI) codes

Status Indicator codes

CPT & HCPCS Codes	SI	APC	Relative Weight	Montana Hospital APC Payment	Montana ASC APC Payment
96900	S	0001	0.4806	$50.46	$37.97
96910	S	0001	0.4806	$50.46	$37.97
96912	S	0001	0.4806	$50.46	$37.97
10021	T	0002	1.1097	$116.52	$87.67
19001	T	0002	1.1097	$116.52	$87.67
36680	T	0002	1.1097	$116.52	$87.67
G0364	T	0002	1.1097	$116.52	$87.67
38220	T	0003	3.1008	$325.58	$244.96
38221	T	0003	3.1008	$325.58	$244.96
10022	T	0004	4.3270	$454.34	$341.83
19000	T	0004	4.3270	$454.34	$341.83

SI codes let you determine how to reimburse non-principal Procedure codes, and are described for you on "(g) The Montana Status Indicator Codes" section of the Montana Facility Fee Schedule

(g) The Montana Status Indicator (SI) Codes

Each APC, CPT and HCPCS code has been assigned a letter that signifies whether the Montana Facility Fee Schedule will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies. Do not use status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X and pay at the fee scheduled amount listed.

SI Code	SI (Status Indicator) Description
A	**Fee Schedules:**[reimburse] **Ambulance**[-related codes only]**.**
B	**Non-allowed item or service. Not a hospital service.**
D	**Discontinued code.**
F	**Acquisition costs paid for Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines.**
G	**Additional payment for Drug/Biological pass-through.**
H	**Additional payment for Pass-though device categories, brachytherapy sources, and radiopharmaceutical agents.**
K	[Not a] **Pass-through** [for] **drugs** [, devices] **and biologicals** [These are to be paid separately from the APC]**.**
L	**Flu and other vaccines.**
N	**No additional payment, payment included in line items with APCs for incidental service. (Packaged codes not paid separately).**
P	**Paid Partial hospitalization per diem payment.**
S	**Significant procedure not subject to multiple procedure discounting.**
T	**Significant procedure, subject to 50% discount on second procedure if present.**
X	**Ancillary services.**
1) Please note the misprint for SI "K" corrected hereon with bracketed text	
2) Please note the clarification for SI "A" corrected hereon with bracketed text	

Status Indicator codes in Summary:

Montana Status Indicator (SI) codes

- **Apply to outpatient services only**
- **Also help identify how APCs and other codes are reimbursed**

Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies

Do not use status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X, and pay at the fee scheduled amount listed

Please note that:

- **SI "A" should only be reimbursed for ambulance-related services, for example stand-by waiting and other services listed on "(d) The Montana Ambulance Fee Schedule" within the Montana Facility Fee Schedule**
- **SI "K" on the "(g) Status Indicator (SI)" portion of our fee schedule is mislabeled and should instead state "not a pass-through drug or device, and needs to be paid separately from the APC"**

Other Useful APC Facts

Outpatient services are grouped into APCs

- There may be several APCs per patient per day
- There may be discounts for multiple APCs
- There may be separately payable CPT and HCPCS services
- Montana CCI (Correct Coding Initiative) edits further assist insurers to understand how to reimburse when multiple codes are involved

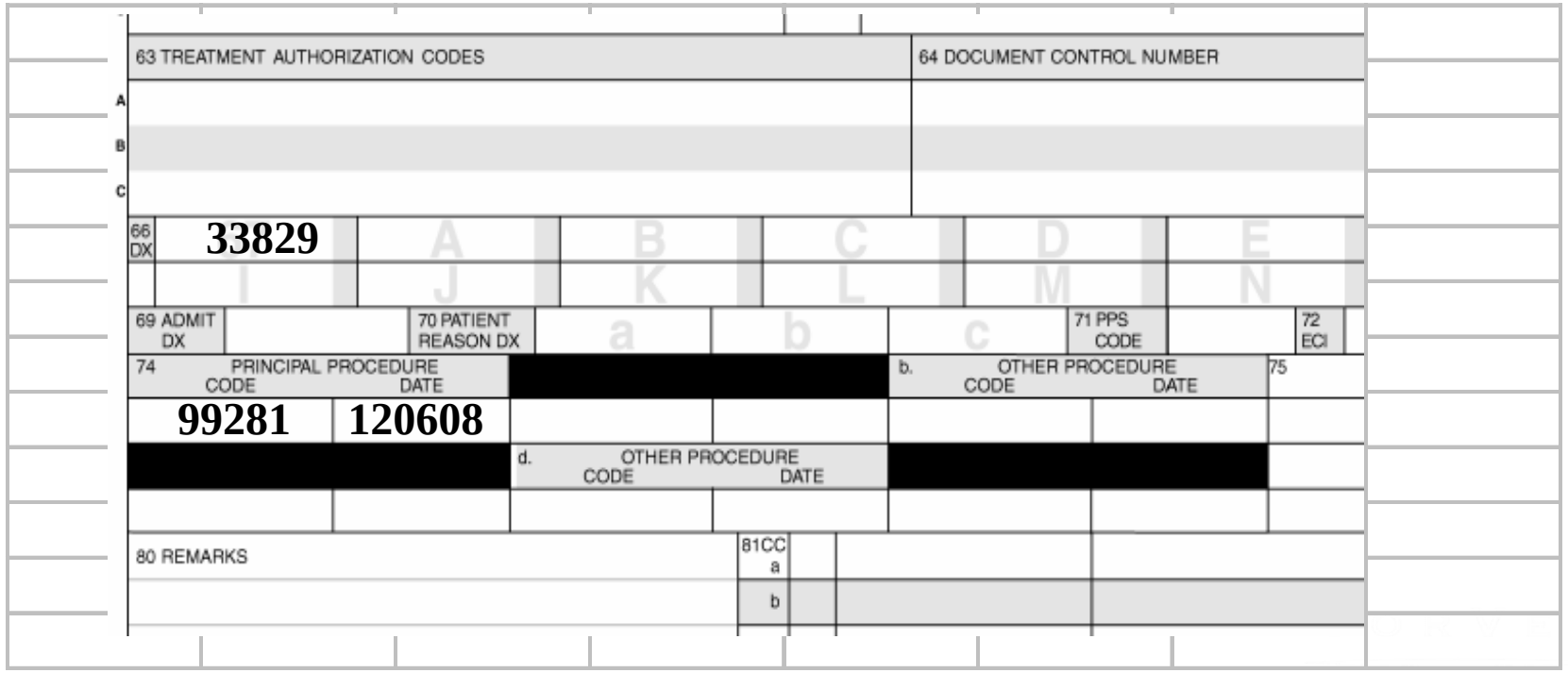
APC reimbursement levels are different for ASCs and Hospitals

- **The basic formula for outpatient reimbursement is the Montana Base Rate times the APC relative weight of a given APC**
- **For hospitals, the Montana Base Rate is $105 beginning 12/01/08**
- **For ASCs, the Montana Base Rate is $79 beginning 12/01/08**
- **If no rate is listed and the code is not otherwise included in the Montana Facility Fee Schedule or the Administrative Rules of Montana, the service is to be paid at 75% of the Montana usual & customary charge***

***In Montana "usual and customary" means the provider's normal charges for a service, and does not include state or regional database information purporting to be usual and customary**

Reimbursing (APC) Outpatient Bills: APC Example # 1

APC Example # 1 (with a Block 4 code of 131) is a hospital outpatient service.

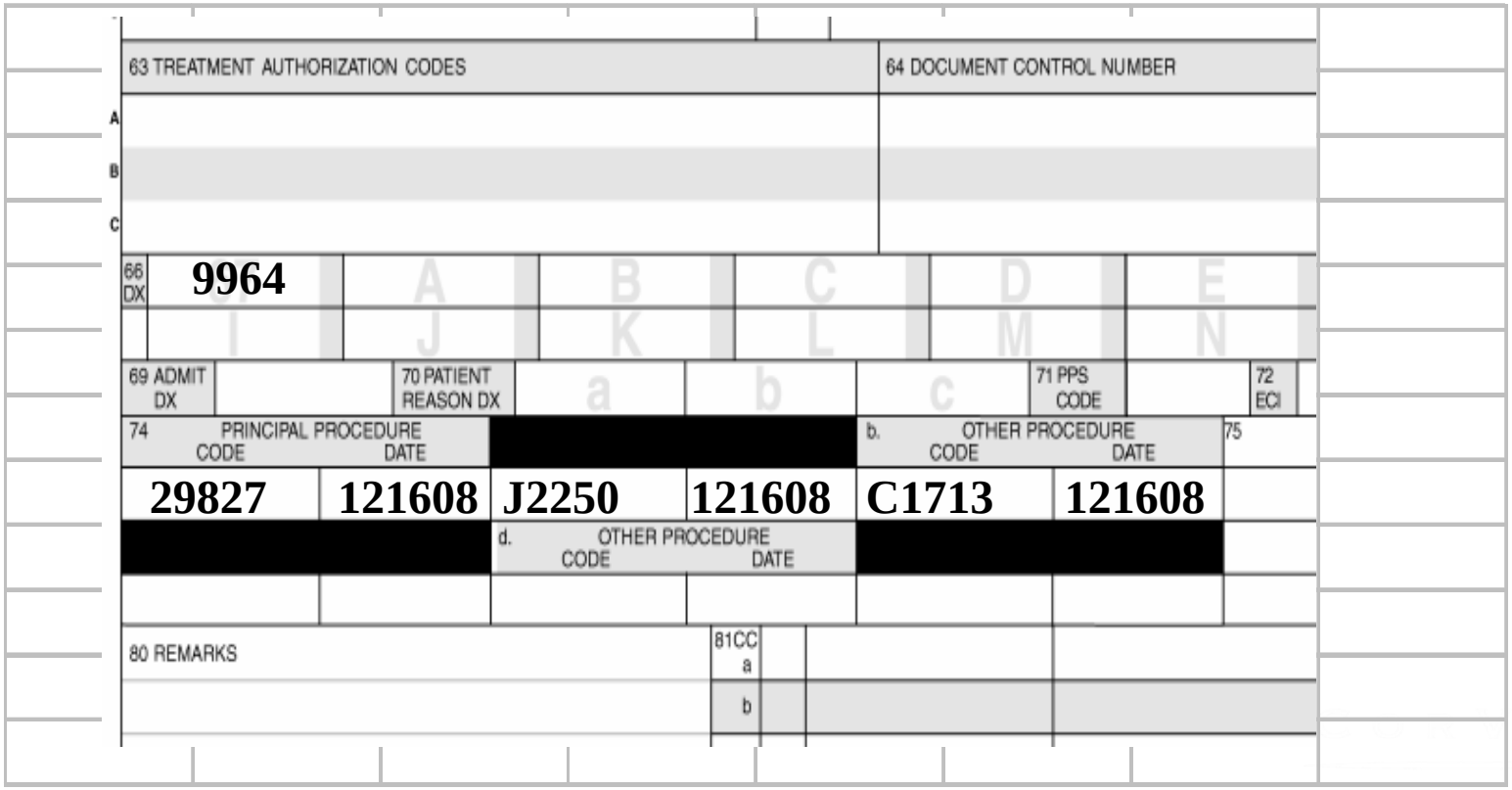


Reimbursing (APC) Outpatient Bills: APC Example # 1

- **The Principal Procedure code is 99281, which the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" of the Facility Fee Schedule as APC 609, and which "(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" reimburses at $83.69 for hospital outpatient services**
- **There are no additional CPT/HCPCS codes on the bill, so there are no additional codes to check Status Indicators for additional reimbursements**
- **The entire reimbursement for this claim is therefore $83.69**

Reimbursing (APC) Outpatient Bills: APC Example # 2

APC Example # 2 (with a Block 4 code of 131) is a hospital outpatient service.



63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER	
A					
B					
C					

66 DX	9964	A	B	C	D	E
	I	J	K	L	M	N

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI

74 PRINCIPAL PROCEDURE CODE	DATE			b. OTHER PROCEDURE CODE	DATE	75
29827	121608	J2250	121608	C1713	121608	
		d. OTHER PROCEDURE CODE	DATE			

80 REMARKS	81CC a			
	b			

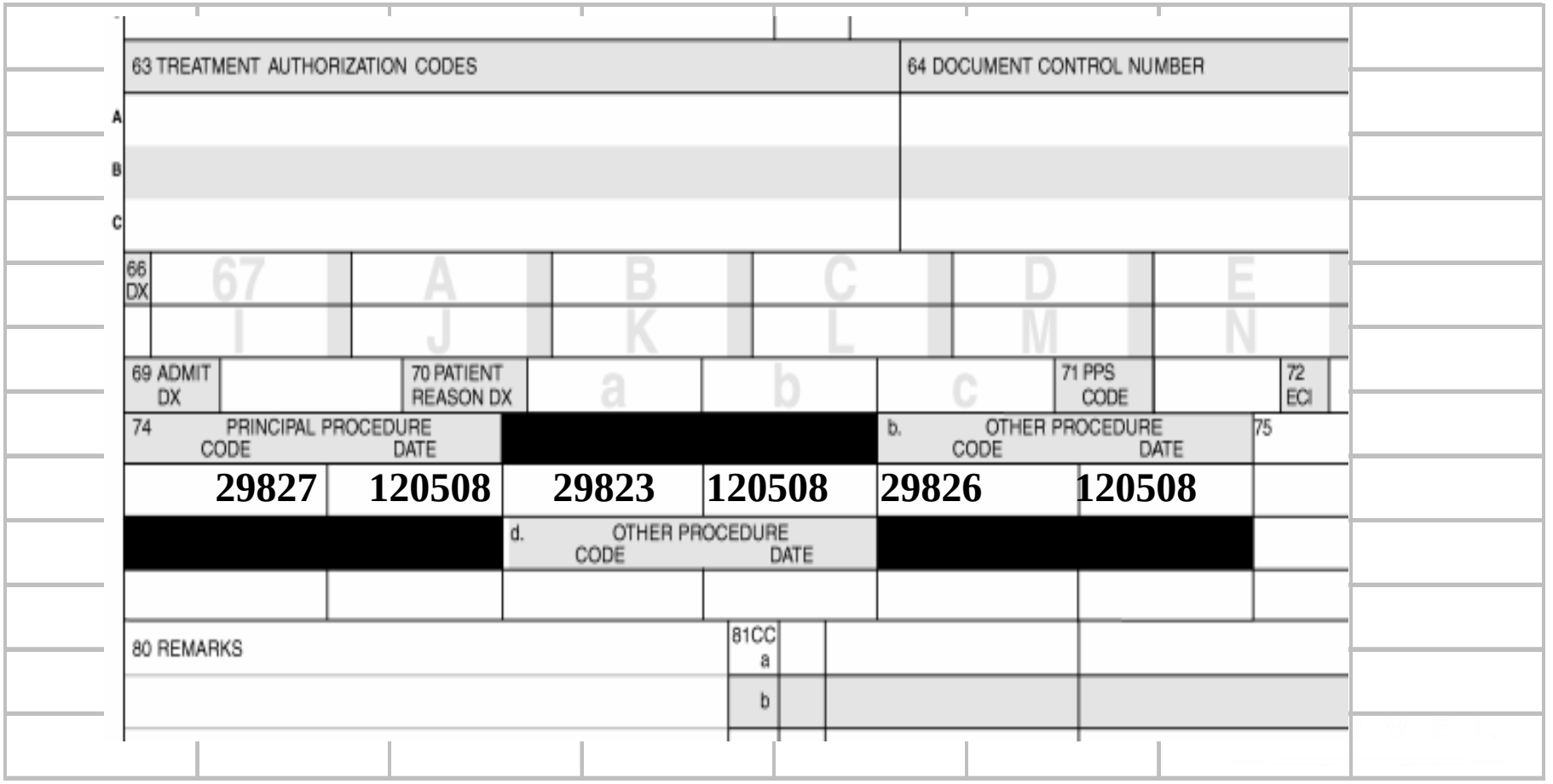
Reimbursing (APC) Outpatient Bills: APC Example # 2

- **The Principal Procedure code is 29827, which the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" of the Facility Fee Schedule lists as APC 42, and which "(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" reimburses at $4,799.26 for hospital outpatient services**
- **There are 2 additional CPT/HCPCS codes on the bill, so there are 2 additional codes to check Status Indicators (SI) in case additional reimbursements should be made for this claim**
- **HCPCS J2250 has a SI of N, meaning it is bundled into the APC, so there is no separate, additional reimbursement for the first non-principal procedure CPT/HCPCS**
- **HCPCS C1713 has a SI of N, meaning it is bundled normally into the APC, so there is no separate, additional reimbursement for the second non-principal procedure CPT/HCPCS either. There is separate methodology for direct reimbursement of costs for implants (that also includes reimbursement for shipping, and an additional payment of 15 percent of cost), so this biller is apparently still gathering together the invoices required to document the additional reimbursement, and will submit the invoices at a later time to the insurer.**

- **The entire reimbursement for this claim at this time is therefore $4,799.26.**

Reimbursing (APC) Outpatient Bills: APC Example # 3

APC Example # 3 (with a Block 4 code of 131) is an hospital outpatient service.



Reimbursing (APC) Outpatient Bills: APC Example # 3

- **The Principal Procedure code is 29827, which the "(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS" of the Facility Fee Schedule lists as APC 42, and which "(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC" reimburses at $4,799.26 for hospital outpatient services**
- **There are 2 additional CPT/HCPCS codes on the bill, so there are 2 additional codes to check Status Indicators (SI) in case additional reimbursements should be made for this claim**
- **CPT 29823 has a SI of T, meaning it is a significant procedure subject to a 50 percent discount as a second procedure, so there is a separate, additional reimbursement of $2,399.63 ($4,799.26 divided by 50 percent)**
- **CPT 29826 has a SI of T, meaning it is a significant procedure subject to a 50 percent discount as a second procedure, so there is a separate, additional reimbursement of $2,399.63 ($4,799.26 divided by 50 percent).**
- **There is separate methodology for direct reimbursement of costs for implants (that also includes reimbursement for shipping, and an additional payment of 15 percent of cost), so this biller is apparently still gathering together the invoices required to document the additional reimbursement, and will submit the invoices and bill for the implant at a later time to the insurer.**

- **The entire reimbursement for this claim at this time is therefore $9,598.52 ($4,799.26+ $2,399.63 $2,399.63).**

Other Considerations

Pay the Bill based on the Fee Schedule

APC rates are based on a "case mix" formula, so insurers should pay the actual fee schedule reimbursement amount, instead of a higher or lower reimbursement amount a medical provider might bill

Section Four: Other Ways of Paying

Not every charge on a WC bill goes through either the MS-DRG or APC reimbursement process. Dependent upon the type of facility and/or the nature of the service, procedure or supply, there can be other ways of paying for a WC bill. For example:

- **Inpatient rehabilitation services are paid at 75% of the usual and customary charges***
- **DME, prosthetics & orthotics (not implantables) are paid at 75% of the usual and customary charges***
- **Ambulance services are to be reimbursed based on the "(d) Montana Ambulance Fee Schedule" within the Montana Facility Fee Schedule. "Urban areas" in Montana are defined as Billings, Great Falls, and Missoula. Only Status Indicator (SI) "A" codes for Ambulance-related services are to be reimbursed.**

***In Montana "usual and customary" means the provider's normal charges for a service, and does not include state or regional database information purporting to be usual and customary**

Section Four: Other Ways of Paying

The following two lists represent the only current Acute Care Hospitals and Ambulatory Surgery Centers Reimbursed by the MS-DRG or APC process

Hospitals

- Advanced Care Hospital of MT, Billings
- Benefis Healthcare, Great Falls
- Bozeman Deaconess, Bozeman
- Central Montana Surgery Hospital, Gt Falls
- Community Medical Center, Missoula
- Deaconess Medical Center, Billings
- Kalispell Regional, Kalispell
- Healthcenter Northwest, Kalispell
- Northern Montana, Havre
- St James Community, Butte
- St. Patrick, Missoula
- St. Peter's Community, Helena
- St. Vincent Hospital, Billings

ASCs

- Big Sky Surgery Center, Missoula
- Billings Cataract & Laser Surgicenter, Billings
- Great Falls Clinic Surgery Center, Great Falls
- Helena Surgicenter, Helena
- Missoula Bone & Joint Surgery Center, Missoula
- Northern Rockies Surgicenter, Billings
- Orthopedic Surgery Center, Kalispell
- Providence Surgery Center, Missoula
- Rocky Mountain Eye Surgery Center, Missoula
- Rocky Mountain Surgical Center, Bozeman
- Same Day Surgery Center, Bozeman
- Summit Surgery Center, Butte
- The Eye Surgicenter, Billings
- Yellowstone Surgery Center, Billings

Section Four: Other Ways of Paying

None of Montana's current Critical Access Hospitals, listed below, are reimbursed by either the MS-DRG or APC process, but instead continue to be reimbursed at 100 percent of usual and customary charges

- Barrett Memorial Hospital, Dillon
- Beartooth, Red Lodge
- Big Horn County Memorial, Hardin
- Big Sandy Medical Center, Big Sandy
- Broadwater Health Center, Townsend
- Clark Fork Valley Hospital, Plains
- Central Montana Medical Center, Lewistown
- Community Hospital of Anaconda
- Dahl Memorial, Ekalaka
- Daniels Memorial, Scobey
- Fallon Medical Complex, Baker
- Frances Mahon Deaconess, Glasgow
- Garfield County Health Center, Jordan
- Glendive Medical Center, Glendive
- Granite County Memorial, Philipsburg
- Liberty County, Chester
- Livingston Memorial Hospital, Livingston
-
- Madison Valley Hospital, Ennis
- Marcus Daly Memorial, Hamilton
- Marias Medical Center, Shelby
- McCone County Hospital, Circle

•Mineral Community, Superior

•Missouri River Medical Center, Fort Benton
•Mountain View Medical Center, White Sulphur Spring
•*North Valley Hospital, Whitefish

•Northeast Montana Health Services, Poplar

•Northern Rockies Medical Center, Cut Bank
•Phillips County Medical Center, Malta

•Pioneer Medical Center, Big Timber

•Pondera Medical Center, Conrad

•Powell County Memorial Hospital, Deer Lodge
•Prairie Community, Terry

•Roosevelt Memorial Medical Center, Culbertson
•Roundup Memorial Healthcare, Roundup
•Rosebud Health Care Center, Forsyth

•Ruby Valley, Sheridan

•Sheridan Memorial, Plentywood

•Sidney Health Center, Sidney

•St. John's Lutheran Hospital, Libby

•St. Luke Community Healthcare, Ronan
•St. Joseph Hospital, Polson

•Stillwater Community, Columbus

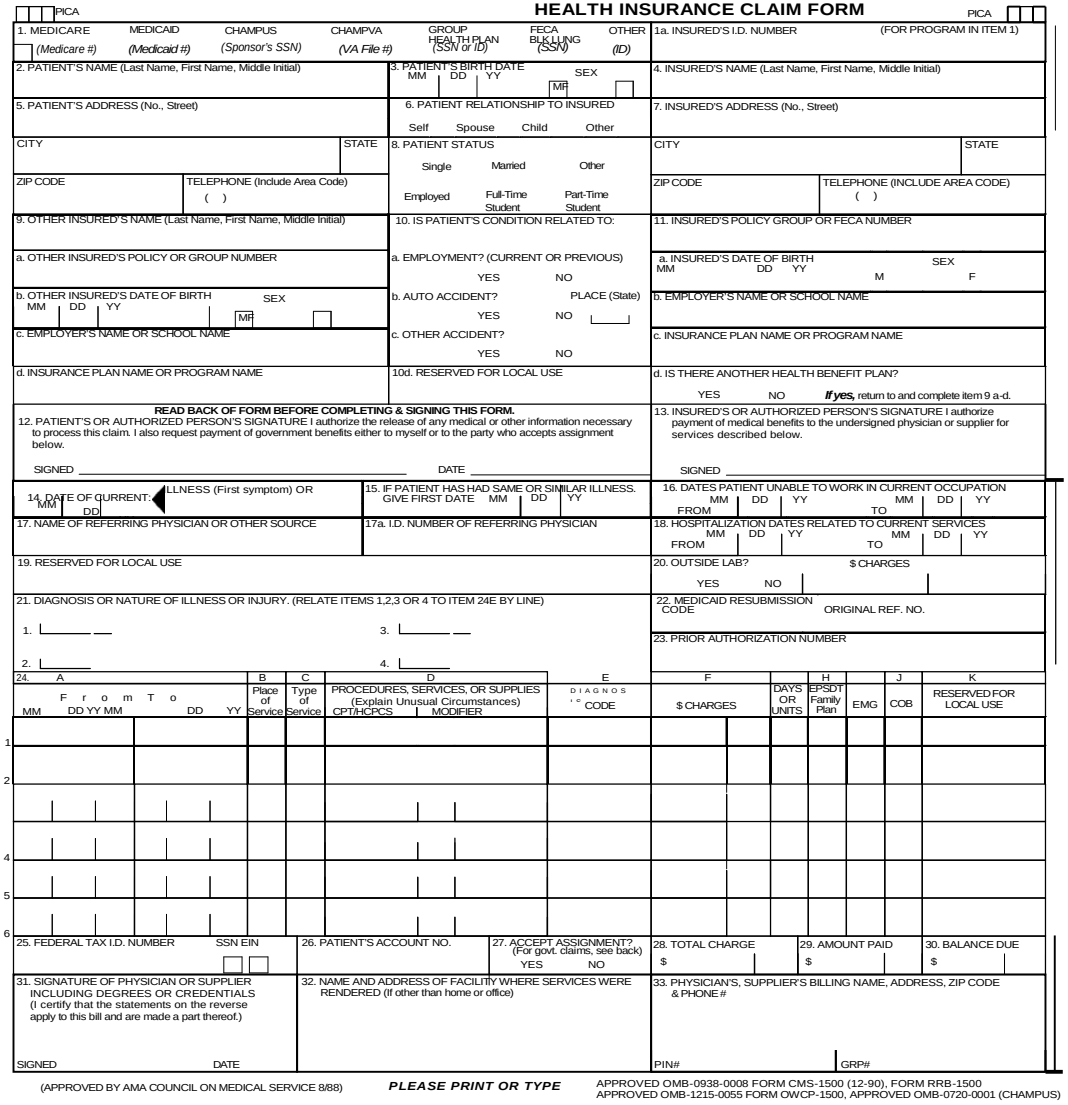
•Teton Medical Center, Choteau
•Wheatland Memorial, Harlowton

Section Five: Aspects of the CMS1500 Form

Ambulatory Surgery Centers (ASCs)

often prefer to use the CMS 1500 form for billing purposes, so here is a brief discussion of the CMS 1500 form showing where the respective form locations are for the billing data you need:

Section 5: the CMS 1500 Form



PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR MM DD

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

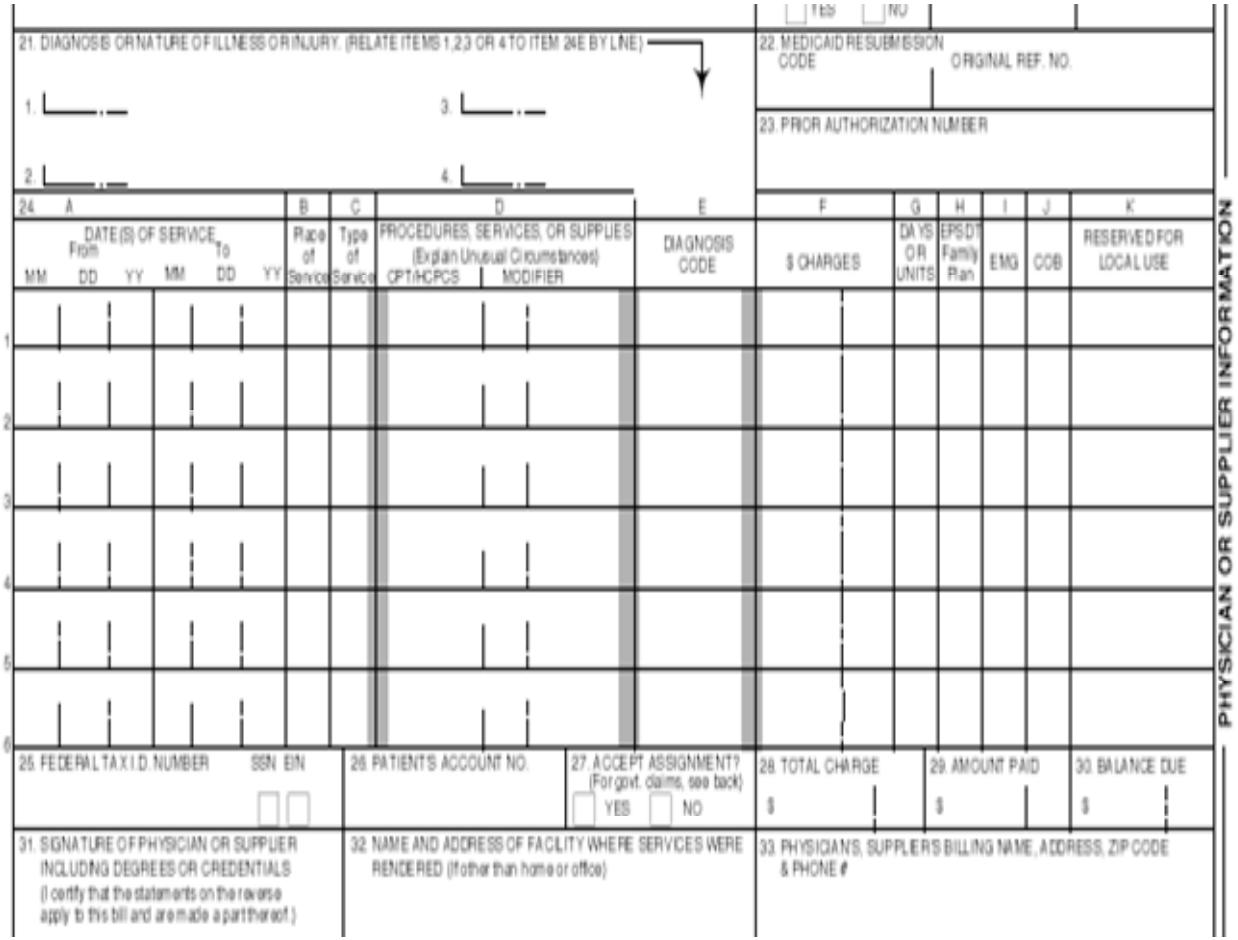
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500 APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Section 5: “21” Data Area from the CMS 1500 FORM



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PHYSICIAN OR SUPPLIER INFORMATION

Section Five: Equivalences to the CMS-1500 Form

Cross-walk of Data Locations on UB-04 and CMS 1500 Forms			
	WW 4/28/09		
Data Type	**UB-04**		**CMS 1500**
inpatient or	cell 4		cell 24 B
outpatient bill			
birthday	cell 10		cell 3
sex	cell 11		cell 3
discharge status	cell 17		NA
ICD-9			
Diagnosis codes	cell 66		cell 21
Procedure codes	cell 74		cell 24 D
CPT/HCPCS			
Procedure codes	cell 74 &		cell 24 D
	column 44		
Charges Total	row 23,		cell 28
	column 47		
Date of service			cell 24 A
Place of service			cell 24 B

Section Six: Other Resources

In 2009 CMS published an 8 page electronic fact sheet on the UB-04 form, including a line-by-line explanation of the purpose of all of the form's sections and purposes. It can be found at: http://www.cms.hhs.gov/MLNProducts/downloads/ub04_fact_sheet.pdf

A much more detailed explanation of the UB-04 form is provided in the CMS publication Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form, CMS-1450 Data Set (126 pages).

Blue Cross Blue Shield of Minnesota has produced a short electronic outline of how providers should fill out a CMS 1500 form (http://www.bluecrossmn,com/bc/wcs/groups/bcbsmn/@

Unit Two: Using the UB-04
Understanding Montana Workers' Compensation (WC) Facility Fee Schedule

A Power Point educational module initially created by the Montana Department of Labor (DLI) in March, 2009. Actual regulations in the Montana Code Annotated and the Administrative Rules of Montana, of course, take precedence in case of any misstatements in this educational module.

The End